STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	01	COMPLETED
		15G238	B. WING		03/13/2014
NAME OF P	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE	
REM OCCAZIO LLC				CASTLE, IN 47362	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	· ·	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
K010000					
	A Life Cafety C	ada Dagartification	K010000		
	1	ode Recertification	K010000		
	1	ducted by the Indiana			
	_	nt of Health in accordance			
	with 42 CFR 48	3.4/0(j).			
	Survey Date: 03	3/13/14			
	J				
	Facility Number				
	Provider Numbe	er: 15G238			
	AIM Number:	100234630			
	Surveyor: Mark	Bugni, Life Safety Code			
	Specialist				
	At this Life Safe	ety Code survey, REM			
	Occazio Inc. wa	s found not in compliance			
	with Requireme	nts for Participation in			
	Medicaid, 42 CI	FR Subpart 483.470(j),			
	Life Safety from	Fire and the 2000			
		ational Fire Protection			
		FPA) 101, Life Safety			
	`	apter 33, Existing			
	· · ·	rd and Care Occupancies.			
	- condendar Bou	and care occupancies.			
	This one story fa	acility was fully			
	_	facility has a fire alarm			
	-	oke detection in the			
		common living areas.			
		a capacity of 8 and had a			
	-	-			
	census of 8 at th	e time of this survey.			
	Calculation of th	ne Evacuation Difficulty			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	of Correction identification number: 15G238	(X2) MULTIPLE CC A. BUILDING B. WING	01	(X3) DATE S COMPLE - 03/13/2	ETED
	PROVIDER OR SUPPLIER CAZIO LLC	1803 R	ADDRESS, CITY, STATE, ZIP CO ILEY RD 'ASTLE, IN 47362	DDE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	Score (E-Score) using NFPA 101A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Prompt with an E-Score of 0.48.				
	Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 03/18/14.				
	The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	01	COMPLI	
		15G238	B. WIN	G		03/13/	2014
NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC (X4) ID SUMMARY STATEMENT OF DEFICIENCIES			1803 RI	ADDRESS, CITY, STATE, ZIP CODE ILEY RD ASTLE, IN 47362		(X5)	
PREFIX TAG	, The state of the	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ГЕ	COMPLETION DATE
K01S018	483.470(j)(1)(i) LIFE SAFETY CO Doors are provided mechanisms suital closed. No doors at the occupant from 32.2.3.6.3, 32.2.3. Doors are self-close in accordance with Exception: Door closed required in building an approved autor accordance with 3 Based on observed facility failed to room doors would door frame and work. This defaffect two clients Hall first and seconds. Findings include Based on observed maintenance sup 1:10 p.m. to 1:20 first and second of doors each failed frames and were to gaps one inches ide of each door this was verified supervisor at the	DE STANDARD d with latches or other ble for keeping the doors are arranged to prevent closing the door. 6.4, 33.2.3.6.3, 33.2.3.6.4 sing or automatic closing 17.2.1.8 osing devices are not gs protected throughout by natic sprinkler system in 2.2.3.5.1 and 33.2.3.5.2. ation and interview, the ensure 2 of 6 sleeping d close and latch into the overe capable of resisting icient practice could is who reside in the South ond client sleeping the south Hall client sleeping room to latch into the door not smoke resistant due wide along the latching in the closed position.	K0	IS018	1. What corrective action will be accomplished? Maintenance has been contact about first and second clients' bedroom doors not latching. Staff will be retrained on report subpar equipment, including household fixtures. Quarterly Health and Safety Assessment will be conducted to ensure group home meets safety standards. Home Manager will evaluate home, monthly to ensure group home meets safety standards and any maintenance issues where the potential to be affected by the same deficient practice and what corrective action will be taked. All residents have the potential to be affected by the same deficient practice. Maintenant has been contacted about first and second clients' bedroom doors not latching. Staff will	ted ting y ts oup p vill n? tial	04/12/2014

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	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 15G238	(X2) MULTIPLE CO A. BUILDING B. WING	01	(X3) DATE SURVEY COMPLETED 03/13/2014
	PROVIDER OR SUPPLIER	1803 RI	.DDRESS, CITY, STATE, ZIP CODE LEY RD ASTLE, IN 47362	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	p.m.		retrained on reporting subpar equipment, including househor fixtures. Quarterly Health ar Safety Assessments will be conducted to ensure group hor meets safety standards. Ho Manager will evaluate home, monthly, to ensure group hor meets safety standards and a maintenance issues will be reports to Maintenance. 3. We measures will be put into play or what systemic changes we be made to ensure that the deficient practice does not recur: Maintenance has been contacted about first and second clients' bedroom doors not latching. Staff will be retrain on reporting subpar equipment including household fixtures. Quarterly Health and Safety Assessments will be conducted ensure group home meets sat standards. Home Manager evaluate home, monthly, to ensure group home meets sat standards and any maintenance issues will be reports to Maintenance. How will the corrective action be monitor to ensure the deficient practive will not recur? Home manawill evaluate home, monthly, then sure group home meets sat standards and any maintenance will evaluate home, monthly, then sure group home meets sat standards and any maintenance will evaluate home, monthly, then sure group home meets sat standards and any maintenance will evaluate home, when on the premises. Quarterly Health Safety Assessments will be conducted to ensure group home meets will be conducted to ensure group home.	ome me ne ny What ace rill en ond ed to fety will fety ce ed ice ager to fety ce ctor he and

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G238	(X2) MULTIPLE CO A. BUILDING B. WING	01		
	PROVIDER OR SUPPLIE	R	1803 R	ADDRESS, CITY, STATE, ZIP CODI ILEY RD 'ASTLE, IN 47362	E	
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN	TATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	TION .D BE .OPRIATE	(X5) COMPLETION DATE
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	meets safety standards 5 is the date by which the systemic changes will be completed? 4/12/14	5. What	DATE

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	DDIC	01	COMPL	ETED
		15G238		A. BUILDING B. WING 01 03/13/2014			
			B. WIN		PDDEGG GUTY GTATE JID GODE		
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
	a.=.aa				LEY RD		
REM OCCAZIO LLC			NEW C	ASTLE, IN 47362			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID DECEMBER OF THE COLUMN TO T			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	T.C.	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE.	DATE
TAG K01S056	483.470(j)(1)(i) LIFE SAFETY CO PROMPT Where an automatinstalled, for either coverage, the syst Section 9.7, 33.2.3 alarm system in at The adequacy of the documented to the jurisdiction. Exception No. 1: In facilities, an automaccordance with North the Installation of Sound two Family Downs, is permitted are not required in sq. ft., provided that finished with lath a providing a 15 minusers. Exception No. 2: Now the Exception No. 3: In evacuation capabication automatic sprinkle with NFPA 13, State of Sprinkler System are not required in sq. ft and in bathroft, provided that swith lath and plasted that the system are not required in sq. ft and in bathroft, provided that swith lath and plasted that should be supported to the system and the system are not required in sq. ft and in bathroft, provided that swith lath and plasted that should be supported to the system and the system are not required in sq. ft and in bathroft. The system are not required in sq. ft and in bathroft. The system are not required in sq. ft and in bathroft. The system are not required in sq. ft and in bathroft. The system are not required in sq. ft and in bathroft. The system are not required in sq. ft and in bathroft. The system are not required in sq. ft and in bathroft. The system are not required in sq. ft and in bathroft.	tic sprinkler system is total or partial building em is in accordance with 3.5.2 and activates the fire accordance with 33.2.3.4.1. The water supply is authority having a total or partial building em is in accordance with 33.2.3.4.1. The water supply is a authority having a total prompt evacuation natic sprinkler system in IFPA 13D, Standard for Sprinkler Systems in One wellings and Manufactured ad. Automatic sprinklers closets not exceeding 24 tooms not exceeding 55 at such spaces are and plaster or materials the thermal barrier. Ito applicable apprompt and slow lity facilities where an ar system is in accordance and for the Installation ms, automatic sprinklers closets not exceeding 24 tooms not exceeding 55 sq. such spaces are finished er or material providing a barrier.		TAG	DEFICIENCY		DATE

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTII	LE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	Ĵ	01	COMPL	
		15G238	B. WING			03/13/	/2014
			ST	REET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	R.	18	03 RII	LEY RD		
REM OC	CAZIO LLC				ASTLE, IN 47362		
(X4) ID	X4) ID SUMMARY STATEMENT OF DEFICIENCIES		ID	ı			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	PREF	iv	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TA		CROSS-REFERENCED TO THE APPROPRIA	TE	DATE
IAG		pancies up to and Including	IA	0			DATE
		eight, are permitted.					
		ight, are permitted.					
	Exception No. 5: N	Not applicable					
	Evention No. 6: 1	nitiation of the fire clarm					
	system is not requ	nitiation of the fire alarm					
		cordance with 33.2.3.5.5.					
	installations in acc	75.144.166 Willi 66.2.6.6.					
	SLOW						
	Where an automa	tic sprinkler system is					
	installed, for either	r total or partial building					
		tem is in accordance with					
		ctivates the fire alarm					
	-	ince with 33.2.3.4.1. The					
		vater supply is documented					
	to the authority ha	ving junsaiction.					
	Exception No. 1: N	Not Applicable					
	Exception No. 2: N	Not Applicable					
	Exception No. 3: I	n prompt and slow					
		ility facilities where an					
	automatic sprinkle	r system is in accordance					
		andard for the Installation					
		ms, automatic sprinklers					
	•	closets not exceeding 24					
		rooms not exceeding 55					
		at such spaces are					
		and plaster or material nute thermal barrier.					
	providing a 15 IIIII	idio iliciliai ballici.					
	Exception No. 4: I	n prompt and slow					
		ility facilities up to and					
	-	ies in height, systems in					
	accordance with N	IFPA 13R, Standard for					
		Sprinkler Systems in					
		pancies up to and Including					
	Four Stories in He	eight, are permitted.					
	Exception No. 5: N	Not Applicable					
	l						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	01	COMPL	ETED
		15G238	238 B. WING			03/13/2014	
			_	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	R			LEY RD		
REM OCCAZIO LLC					ASTLE, IN 47362		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TF	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	-	DATE
	Exception No. 6: In system is not requinstallations in accordance installed, for either coverage, the system in accordance adequacy of the word to the authority has 33.2.3.5.2. Exception No. 1: Note that is the system in accordance and installed, for either coverage, the system in accordance adequacy of the word to the authority has 33.2.3.5.2. Exception No. 1: Note that is the system in accordance and installed in the system in a s	nitiation of the fire alarm aired for existing cordance with 33.2.3.5.5. tic sprinkler system is a total or partial building tem is in accordance with ctivates the fire alarm ance with 33.2.3.4.1. The vater supply is documented ving jurisdiction. Not Applicable. In slow and impractical dility facilities, an automatic an accordance with NFPA and the Installation of an One and Two Family anufactured Homes, with a supply, is permitted. All and closets are sprinklered. For are not required in acceding 55 sq. ft., provided are finished with lath and as providing a 15 minute. Not Applicable. Not Applicable. In impractical evacuation approximate and including four and including four and for the Installation of and Including Four and Including Four					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 01 COMPLE				
		15G238	B. WIN	G		03/13/	2014
	PROVIDER OR SUPPLIER		<u> </u>	1803 R	ADDRESS, CITY, STATE, ZIP CODE		
REM OC	CAZIO LLC			NEW C	ASTLE, IN 47362		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	, The state of the	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	ΓE	COMPLETION
TAG		<u> </u>		TAG	DEFICIENCY)		DATE
TAG	habitable areas and Automatic sprinkle bathrooms not exception spaces a plaster or materials thermal barrier. Exception No. 6: In system is not requinstallations in accepta Based on observation facility failed to were provided were provided woof paint. LSC 9. Standard for the Maintenance of Variation Protection System requires sprinkle foreign materials damage and shall proper orientation sidewall). Any smellaced that is proper damaged, loaded orientation. This affect all clients affect all clients affect all clients are facility on 03	ordance with 33.2.3.5.5. ations and interview, the ensure 3 of 13 rooms ith sprinkler heads free 7.5 refers to NFPA 25, Inspection, Testing, and Water-Based Fire ms. NFPA 25, 2-2.1.1 rs to be free of corrosion, paint, and physical I be installed in the n (upright, pendent, or prinkler shall be ainted, corroded, por in the improper deficient practice could in the facility.	KO	TAG 18056	1. What corrective action will be accomplished? Maintenance has been contact about replacing sprinkler head office, client bedroom #2 and #due to current heads being painted. Staff will be retrained on reporting subpar equipment including household fixtures. Quarterly Health and Safety Assessments will be conducted ensure group home meets safe standards. Home Manager we evaluate home, monthly to ensure group home meets safety standards and any maintenance issues will be reports to Maintenance. 2. How will we identify other residents having the potential to be affected by the same deficient practice a what corrective action will be taken? All residents have the potential to be affected by the same deficient practice. Maintenance has been contact.	ted s in t4, d to ety vill sure ce	DATE 04/12/2014
	_	the maintenance			about first and second clients'		
	_	raff office sprinkler,			bedroom doors not latching. · Staff will be retrained on repor	tina	
		oom # 2 sprinkler, and			subpar equipment, including	ui ig	
		oom # 4 sprinkler were			household fixtures. · Quarterly	,	
	covered in brown	n paint. This was			Health and Safety Assessmen		

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	N OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
15G238		A. BUILDING 01	- 03/13/2014	
130230		B. WING		
	F PROVIDER OR SUPPLIER CCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP COD 1803 RILEY RD NEW CASTLE, IN 47362	E	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI TAG DEFICIENCY)	LD BE COMPLETION DATE	
	verified by the maintenance supervisor at the time of observations and acknowledged at the exit conference on 03/13/14 at 2:10 p.m.	will be conducted to ensure home meets safety stand Home Manager will evaluate home, monthly to ensure home meets safety stand and any maintenance iss be reports to Maintenance What measures will be place or what systemic changes will be made to ensure that the deficient practice does not recur: Maintenance has been or about first and second clibedroom doors not latchi Staff will be retrained on subpar equipment, include household fixtures. Qualenth and Safety Assess will be conducted to ensure home meets safety stand and any maintenance iss be reports to Maintenance how will the corrective abe monitored to ensure deficient practice will not recur? Home manager evaluate home, monthly, ensure group home meet standards and any maintenance. Program will evaluate home, when premises. Quarterly He Safety Assessments will conducted to ensure group meets safety standards is the date by which the systemic changes will be	ards. ate group ards ues will e. 3. but into contacted ents' ng. reporting ing arterly sments re group ards. ate group ards ues will e. 4. action the bt will to s safety enance Director on the alth and be up home 5. What	

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	T OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA DEF CORRECTION IDENTIFICATION NUMBER: 15G238	(X2) MULTIPLE CO A. BUILDING B. WING	01	— COM	TE SURVEY MPLETED 13/2014
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, ZIP (SILEY RD	CODE	
REM OC	CAZIO LLC		CASTLE, IN 47362		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	RRECTION SHOULD BE APPROPRIATE	(X5) COMPLETION DATE
			completed? 4/12/14		

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